Medical Group Practice in California

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SUMMARY

A 1950 study of group practice in California reveals 52 "true general medical groups" among 123 medical organizations surveyed, involving 634 full-time and 215 part-time physicians. The groups, in contrast to the national patterns, tend to be larger, younger and more urban. There is also a greater tendency toward unit hospital affiliation (30 groups) and operation of group prepayment plans (10 groups).

In general similarity to the national scene, California groups are most frequently organized as private partnerships with a salary method of remuneration sometimes augmented by a share of net earnings. The range of medical and technical services offered varies widely with the size of the group.

The combination of group prepayment, medical group practice, and coordinated medical-hospital centers seems to offer special opportunities for satisfactory practice and adequate medical care.

GROUP practice has developed as an increasingly significant form of medical organization in the United States. With the stated objectives of coordinating the technical complexity of modern medicine and achieving economy and efficiency of patient care, the group movement has attracted the attention of a growing number of physicians. Literature on the subject was recently summarized by the American Medical Association.[1] A comprehensive national survey of 368 medical groups was reported in 1946 by the Public Health Service.[2-8] The present study of group practice in California was undertaken to determine the nature of the movement in this state, and to compare it with the reported data for the nation as a whole.

Definition of Group Practice

"Group practice" is a term used rather loosely with varied applications to the association of physicians in offices, clinics, hospitals and the like. For the purposes of this study, a fairly specific definition of "true" medical group practice was adopted in an effort to distinguish between formal group affiliation and the many limited forms of cooperation among physicians. The requirements of a "true general medical group" were established as follows:

1. A systematic association of at least three full-time physicians;
2. More than one specialty of medicine represented;
3. Joint use of office facilities and auxiliary personnel;
4. Formal organization for administration and financing;
5. Pooling of income and sharing of common overhead expenses, with net payments to physicians made according to a prearranged plan.

Thus, many types of medical affiliations were excluded from the analysis, for many did not satisfy all the five criteria.

METHODS AND MATERIALS

In the spring of 1950, a list of all known groups, clinics, medical associations and the like was compiled from every available source—including the state registry of licensed clinics, the Public Health Service list of groups surveyed in 1946,[6] the files of groups participating in the California Physicians' Service and the personal knowledge of physicians and others throughout the state. A total of 123 organizations were listed. To each was sent a specially designed questionnaire, which had been previously field-tested and modified accordingly. Incomplete returns were followed up by mail and telephone. A representative sample of the 52 groups subsequently designated as "true general medical groups" were visited in person to validate the questionnaire and provide first-hand experience with existing group patterns.

Response to questionnaire. Of the 123 units canvassed, 92, or 75 per cent, completed the questionnaire. When the criteria of true group practice were applied to the data supplied, 52 groups, or 56.5 per cent of the units reporting, met the full requirements. These 52 groups, therefore, are the basis for the analysis which follows. This response and this proportion of "true" groups correspond quite closely with the experience of the national survey.[8]

ANALYSIS OF FINDINGS

Extent of Group Practice

Current estimates for the United States as a whole indicate some 500 medical groups, with fewer than 5,000 physicians, full- and part-time. Although this constitutes less than 3 per cent of the active profession, there is much evidence (including the Amer-

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ican Medical Association survey of 1945[9]) that many more physicians are interested in the movement and are undertaking less formal modes of group association. Of the 368 groups identified in the 1946 national survey, some 26 were listed for California, and the state had 315 of the 3,084 full-time group physicians reported at that time.[8] The present study, however, designated 52 groups and 634 full-time physicians for the state in 1950—although only eight of these California groups have been organized since 1946. These differences are important in comparing the national and state data for the two years.

The 52 California groups identified in 1950 involve a total of 849 physicians (634 full-time and 215 part-time), constituting about 8 per cent of the practicing physicians in the state. As there were 1,037 physicians connected with all of the 92 units which returned the questionnaire, it is suggested that an even greater proportion of the California medical profession is involved in some form of group affiliation.

Geographical Distribution of Groups

Medical group practice in California is predominantly an urban phenomenon; 55 per cent of groups and 73 per cent of all the group physicians are located in the two major metropolitan areas (Table 1). Los Angeles County has 31 per cent of the groups and 28 per cent of the physicians, while the San Francisco Bay Area has 24 per cent of all groups and 45 per cent of all group physicians. Of the ten groups operating their own prepayment plan, eight are in these two areas, and a ninth—in San Diego—is also located in a large urban community.

TABLE 1.—*Distribution of Groups and of Physicians in Group Practice by County—California 1950*

County	Groups		Physicians in Group Practice	
	Number	Per Cent	Number	Per Cent
All counties	52	100	849	100.0
Los Angeles	16	31	236	27.8
San Mateo	5	10	40	4.7
San Diego	4	8	46	5.4
Alameda	3	6	212	25.0
Santa Barbara	3	6	40	4.7
San Bernardino	3	6	40	4.7
San Francisco	2	4	77	9.1
Santa Clara	2	4	55	6.5
Stanislaus	2	4	13	1.5
Tulare	2	4	12	1.4
Yuba	1	2	12	1.4
Orange	1	2	10	1.2
Sacramento	1	2	9	1.1
Fresno	1	2	8	0.9
Riverside	1	2	8	0.9
Sonoma	1	2	8	0.9
San Luis Obispo	1	2	7	0.8
Kern	1	2	7	0.8
Placer	1	2	5	0.6
Santa Cruz	1	2	4	0.5

Percentages do not add up to 100 because of rounding.

General Characteristics of the Groups

Group affiliation. Forty-eight, or 92 per cent, are private medical groups. The other four are industrial, cooperative and university-affiliated. This distribution is similar to the national pattern.[2]

Primary activity. All of the 52 groups are organized to provide general medical care. (Among the original 123 units canvassed, there were also eight single-specialty groups, two units practicing only part-time, and thirty less formal associations.)

Size of group. Table 2 reflects the great weight of the few very large groups now in operation. Although four-fifths (41) of all groups are small (fewer than eleven full-time physicians), they account for less than two-fifths of the total number of full-time physicians. But the six largest groups include over half of all the full-time physicians. In addition, two groups defined as small in terms of number of full-time physicians, nevertheless have a great many part-time members. Nationally, the groups tend to be smaller; California has twice as large a proportion of its full-time physicians in very large groups as has the United States.[8]

Age of groups. Group practice in the state is relatively mature; thirteen of the 52 groups are 21 or more years old, and 32 units are 11 or more years old. As might be expected, only five groups (10 per cent) were organized in California during World War II. In the five immediate postwar years, however, almost as many new groups were formed (15) as in the ten years preceding the war. Again, the national pattern is different—in that there is a greater preponderance of older groups. This is also reflected in the fact that the mean age of California groups is 14.3 years, compared with 19.9 years for the whole United States.[3]

Form of organization. Nearly three-quarters of the California groups are organized as partnerships —12 having partners only and 25 employing other physicians as well. Eleven groups are organized s single physician owner with employed physicians. In only three groups are all physicians employed by a

TABLE 2.—*Size of Groups—California 1950*

Size of Group (in Number of Full-Time Physicians in Group)	Groups		Physicians					
			Total		Full-time		Part-time	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
All groups	52	100	849	100.0	634	100.0	215	100.0
3-5	21	40	159	18.7	84	13.3	75	34.8
6-10	20	38	270	31.8	160	25.2	110	51.2
11-20	5	10	73	8.6	67	10.6	6	2.8
21 and over	6	12	347	40.9	323	51.0	24	11.2

Percentages do not add up to 100 because of rounding.

sponsoring organization. Table 3 presents the full distribution. This pattern is similar to that reported for the nation as a whole.[8]

Size of community. Although very few groups (5, or 10 per cent) are in rural communities, there is a fairly even distribution of groups in small, medium-sized and large cities (Table 4). Many of these small cities, however, are actually suburbs of metropolitan centers. The fact that the big city groups are also the largest means that the great majority of group physicians (73 per cent) are in metropolitan areas. When part-time physicians are eliminated from the analysis, however, there results a much more even distribution of full-time physicians among the small and large cities.

In contrast, the national pattern shows a greater proportion of groups in rural and small town communities, and fewer in the large cities.[8] In general, California group practice is a metropolitan phenomenon, while the characteristic national site is the small city.

Interrelated factors. No striking correlation exists between the size of the group and the size of the community — although only one group with more than eleven full-time physicians is located in a community of less than 25,000 population. In the nation as a whole, however, there is a definite tendency for small groups to be in small communities and large in large.[8]

There is similarly no close relationship between size and age of group in California—although in the national pattern the older groups tend to be the larger as well.[3]

Considering the factors of size of community and age of groups, there is some slight evidence that the older units are located in the larger communities. This is true also for the nation as a whole.[3]

The size of the group bears definite relationship to the form of group organization. The larger groups tend to be predominantly organized as partnerships with additional employed physicians, while the smaller groups rely more upon the single physician owner and the partnership-only forms. This is equally true for the United States as a whole.[2]

The form of organization does not seem to be related to either the age of the group or the size of the community.

TABLE 3.—*Form of Group Organization—California 1950*

Form of Group Organization	Groups		Physicians	
	Number	Per Cent	Number	Per Cent
All forms	52	100	849	100.0
Partnership plus employed physicians	25	48	567	66.9
Partnership only	12	23	75	8.8
Single physician owner plus employed physicians	11	21	98	11.5
All physicians employed by sponsoring organization	3	6	101	11.9
Other*	1	2	8	0.9

*Questionnaire data not clear.

TABLE 4.—*Distribution of Groups and Physicians by Size of Community—California 1950*

Size of Community	Groups		Physicians	
	Number	Per Cent	Number	Per Cent
All communities	52	100	849	100.0
Under 5,000	1	2	5	0.6
5,000 - 9,999	4	8	35	4.1
10,000 - 24,999	12	23	83	9.8
25,000 - 99,999	15	29	183	21.6
100,000 - 499,999	10	19	287	33.8
500,000 and over	10	19	256	30.2

Percentages do not add to 100 because of rounding.

Prepayment Characteristics of the Groups

While almost all the groups care for patients enrolled in the various medical insurance plans operating in the state, there are ten which operate their own plan as an integral part of the group organization. These groups tend to be very much larger and more urban than those providing private fee services only. The prepayment groups are also more commonly organized by a sponsoring organization, more frequently are designed as partnerships with employed physicians, and tend to provide a broader array of medical and technical services. The mean size of California prepayment groups is 30.8 full-time physicians, as compared with only 7.8 for all others in the state and 11.1 for the nation as a whole.[8] The over-all proportion of groups with their own prepayment plan is similar for the state (19 per cent) and the nation (15 per cent), although over half of all physicians in California are in prepayment groups as compared with only 20 per cent for the United States (see Table 5).

Hospital Relationships

Eight, or 15 per cent, of the total number of groups in California operated their own hospital in 1950. Another 22, or 42 per cent, have a group affiliation with at least one hospital in the community. This compares with the national figure of 32 per cent of all groups having their "own hospital."[8] (Whether this means ownership or unit affiliation is not clear in the United States study.)

TABLE 5.—*Distribution of Groups, and Physicians in Groups, With and Without Prepayment Plan—California 1950*

Operation of Prepayment Plan	Groups		Physicians					
			Total		Full-time		Part-time	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
All groups	52	100	849	100.0	634	100.0	215	100.0
Groups with own prepayment plan	10	19	483	56.8	308	48.6	175	81.4
Groups without prepayment plan	42	81	366	43.2	326	51.4	40	18.6

TABLE 6.—*Occurrence of Medical Specialties—California 1950*

Medical Specialty	Groups Having Each Specialty (Total of 52 Groups) Number	Per Cent
Surgery	48	92
Internal medicine	45	87
Obstetrics-gynecology	44	85
Radiology	32	62
Pediatrics	31	60
Ear, nose, and throat	30	58
Eye	22	43
Orthopedics	22	43
Urology	22	43
Neurology-psychiatry	12	24
Dermatology	11	22
Pathology	10	20
General practice	6	12
Other*	8	16

*"Other" includes the following: Allergy, 3 groups; Industrial medicine, 3 groups; Neurosurgery, 2 groups; Endocrinology, 2 groups; Aviation medicine, 1 group; Proctology, 1 group.

Four of the ten California prepayment groups operate their own hospital, while another three are affiliated as a group with a local facility.

Group-owned hospitals range in size from 15 to 300 beds, although one large state-wide group operates a network of hospitals now totaling about 500 beds. The United States range in 1946 was 6 to 350 beds, with a median of 48.[8]

Services Provided by the Groups

Medical specialties. Table 6 indicates that the specialties of surgery, internal medicine and obstetrics-gynecology appear to be basic to any group, with radiology and pediatrics commonly offered as well. The larger groups reported a wider array of specialties than did the small units, although dermatology and pathology were rare in all groups. About one-third of all full-time physicians in California group practice are certified as specialists by the American Boards. The national survey reported a greater amount of specialty service than is indicated in the figures for California.[2]

Preventive services. Regardless of size, most California groups reported that immunization, routine laboratory screening tests and periodic physical examinations are offered to their patients. But the organized types of preventive service—child health conferences, health education, and the like—are offered rarely, and then only by the larger organizations.

Auxiliary technical services. Basic laboratory services are rendered by most groups, while physical therapy is included by three-quarters of the groups. Other auxiliary services are relatively rare, and vary directly in rate of occurrence with the size of the group. Dietetic instruction is provided by less than 40 per cent of all groups, and less than 40 per cent have a pharmacy operating in association with them.

Administrative and library personnel. Most of the groups (89 per cent) have a full-time business manager, while only 56 per cent reported a full-time medical director. Only 23 per cent maintain the services of a record-room librarian. This closely reflects the national pattern reported in 1946.[8] Again, most of the groups having such personnel are the larger ones.

Ratios of full-time personnel. The total number of full-time nurses in California groups (881) constitutes a ratio of 1.4 per physician. Groups with their own hospital, however, reported 2.8 nurses per physician, as compared with a ratio of 0.9 for clinics only. These figures are higher than the ratio of 0.55 nurses per physician reported in 1946 for the United States as a whole.[8]

The total of 238 technicians provides a ratio of 0.4 per full-time physician, again with a slightly higher ratio for groups owning hospitals. Administrative and clerical personnel occur in a ratio of 1.3 per full-time physician (2.1 for groups with hospitals and 1.2 for groups without). An over-all total of 2,798 full-time personnel was reported by the 52 groups.

Methods of Practice and Administration

Initial choice of physician. In two-thirds of the California groups, the patient himself determines the physician to whom he is initially referred. In the remaining one-third, this decision is made by a nurse or clerical receptionist. None of the groups appear to use a physician for initial evaluation. In the prepayment groups, 80 per cent accept the patient's initial self-referral.

Patient-physician relationship. In about one-half of the groups in the state, one physician assumes centrol control of the patient's care throughout all episodes of illness and refers to the various specialists as indicated. In the other half, patients are directed at once to the specialist indicated by the chief complaint in each episode of illness. The smaller groups, however, use the central physician method much more commonly (67 per cent of these groups), while five of the six very large units refer patients directly to the indicated specialist.

Medical records. Almost all (90 per cent) of the groups reported that all medical records for each patient are kept in a single folder, and (in all but one case) this folder accompanies the patient throughout the various services of the group.

Billing of patients. In about one-half the groups, the patient is billed by the group as a unit, and the total charge reflects the number of referrals or consultations by different group physicians. In the other half of the groups, the patient is billed by the group as a unit (unit billing is implied in the criteria of group practice), but without regard to the number of intragroup referrals or consultations. Among this latter group, of course, are the ten prepayment organizations whose premium charges obviously do not relate to volume of service rendered the individual patient. Considering only the private fee groups, therefore, more use the former method (25 groups) than the single fee system (17 groups). The system of billing was found to bear no consistent relationship either to size of group or to form of group organization.

TABLE 7.—*Methods of Remuneration of Physicians in Group Practice—California 1950*

Methods of Remuneration	Physicians	
	Number	Per Cent
All methods	849	100.0
Salary (alone,or in combination)	712	84.0
Salary only	472	55.7
Salary, plus bonus or percentage of net profit	240	28.3
Percentage of net profit, only	63	7.4
Individual fees for service (alone, or in combination)	74	8.6
Individual fees for service, only	66	7.7
Individual fees for service plus percentage of net profit	8	0.9

Methods of remuneration of physicians. The great majority of physicians in group practice in California receive partially or entirely a salary form of income (Table 7). Over half have a straight salary, while another quarter receive a bonus or percentage of net profit in addition. The remaining minority are divided about evenly between percentage of net profit only and individual fees for service.

Payment methods are closely related to form of organization. Partnerships which employ other physicians emphasize the salary method, while the majority of partnership-only groups base incomes on the percentage of net earnings or on the individual fee method. Physicians employed by a single physician-owner are much more likely to receive a bonus or other additional income than are those employed by an outside organization.

Criteria of remuneration of physicians. The most common criterion reported was the owner or partner status of the physician (61 per cent of groups). About half consider training, accreditation, experience and professional status. More than one-third of the groups consider seniority in the organization. A relatively small number take into account the amount of service rendered or the number of patients brought into the group. The experience in the nation as a whole is similar,[2] and thus the emphasis in group practice is more on professional criteria and less on volume of work performed. This is particularly noted in the larger groups and in those with their own prepayment plans.

Physician welfare. All groups report various benefits specially organized for physicians. Ninety-eight per cent provide for vacations (92 per cent with pay), 96 per cent allow for rotation of on-duty status, 84 per cent provide sick leave, and 82 per cent allow attendance at medical conventions (although only 40 per cent pay their members' expenses at such conventions). Commonly included also are staff educational programs (71 per cent), leave of absence for postgraduate study (53 per cent), and professional travel or mileage expenses (39 per cent). An organized retirement plan is reported by only 20 per cent of the groups as against 32 per cent of 22 groups studied throughout the nation in 1947.[4] Again, the larger groups appear to provide such benefits more commonly than do the smaller ones.

Research. Twenty-two, or 42 per cent, of the groups provide facilities for medical research. Sixteen of these groups include in their budgets items for equipment and expenses for research. In 1950, nine of the groups had received outside gifts or grants for their research studies.

COMMENT

A few generalizations emerge from the mass of data. The 52 medical groups in California in 1950 involve a significant segment of the medical profession of the state—and represent a growing trend. In contrast with the national pattern, the California groups are younger, larger, more urban, and more commonly associated with hospitals and prepayment plans. The four very large groups in the state tend to dominate the statistical picture, and determine the most characteristic aspects of the California pattern.

The relative stability and long history of the medical groups is significant, as is the rate of formation of groups in the postwar years. These newer groups, interestingly enough, tend to be smaller and less urban than the general pattern. As in the rest of the country, the salary method of payment and the private partnership form of organization predominate, especially in the large and prepayment groups.

Weaknesses

The data as reported indicate a definite gap between the promise and the practice of group medicine. This is reflected in various aspects of group organization and function.

A basic theoretical advantage of group practice is the coordination of complex modern medical services for the individual patient—or even better, the individual family. This calls for a nucleus of broadly oriented general physicians who function as personal health counsellors, calling upon and coordinating the specialty consultants as indicated in each case. Thus, central patient responsibility and continuity of patient care can be combined with the full array of specialist and technical service.

This survey reveals that most groups in the state are organized by specialists, that at least half assign the patient directly to a specialty department for each episode of illness, and that either the patient or a receptionist decides upon this initial selection of specialist. This "fragmentation" process—a basic characteristic of medical practice in America today — appears more commonly in the larger urban groups than in the less complex organizations.

In some groups, practical barriers still exist to the intragroup referral of patients—supposedly a functional essence of one type of group practice. In half the groups studied, the patient pays additional charges for each referral, and almost one-third of groups base payments to physicians at least partially on the number of patients handled by each individual physician. In the prepayment groups the physician and the patient may avoid economic deterrents, which exist in certain plans, to intragroup referral.

Group practice has an unusual potential for preventive medicine, since the team of trained personnel in group medical centers has greater facilities for the special techniques of prevention than does the solo practitioner. The data show, however, that relatively little emphasis is given by California groups to the planning of organized preventive services—although the individual techniques (immunization, health examination, etc.) are commonly reported. A related observation is the relatively rare employment of such auxiliary personnel as public health nurses, social workers, nutritionists, health educators, etc., who could immeasurably enhance the preventive program, while increasing the quality and economy of the over-all group service.

A final comment relates to the persistence of elements of economic competition among physicians in a group. An important advantage of one form of group practice lies in the elimination of professional competition and its replacement with cooperation and financial sharing. While this *is* true of a considerable portion of California groups, there remain significant differences among the units studied. In some of the groups, the individual physician benefits financially by retaining rather than referring the patient and competes with his colleagues in terms of volume of service rendered. The over-all income of the unit reflects the total number of visits and operations in all but the prepayment groups. A few of the groups still reimburse physicians according to the number of individual services rendered to each patient.

Advantages

To a considerable degree the theoretical advantages of group practice are demonstrated in the California experience. Almost all of the groups maintain their own coordinated medical center for the efficiency of physicians and the convenience of patients. Over half are able to maintain group practice in the hospital as well.

The administrative arrangements that constitute group practice free physicians from business dealings with patients, guarantee them a secure and steady income, provide comprehensive clinical facilities and auxiliary personnel, make possible ready consultation and referral relationships, provide a regular schedule of duty and free time, and present special educational and research opportunities.

In general, the groups bring together a fairly broad array of specialists and auxiliary personnel and provide basic laboratory and other technical facilities, thus enhancing the potential for scientific practice and for comprehensive service to patients.

The personal advantages to physicians—in terms of economic security, vacations and sick leave arrangements, travel subsidies, etc., are well demonstrated. The stability and growth of older groups and the appearance of new ones testify to the attractiveness of the general arrangements to many physicians.

A highly significant impact of the medical groups on professional practice in the state is the shift in them away from the traditional pattern of individual fees for each item of service rendered, to the group method of guaranteed income with sharing of net surplus based upon professional qualifications.

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REFERENCES

1. American Medical Association, Bureau of Medical Economic Research: An Annotated Bibliography of Group Practice, Bulletin 85, The Association, Chicago, 1951.

2. Goldstein, M. S.: Medical Group Practice in the United States, IV. Organization and Administrative Practices (reprinted with additions), J.A.M.A., 136:857-861, March 27, 1948.

3. Goldstein, M.S.: Medical Group Practice in the United States, V. Growth of Groups, Journal-Lancet, 69:42-46, Feb. 1949.

4. Goldstein, M. S.: Medical Group Practice in the United States, VI. Income of Physicians (reprinted with additions), J.A.M.A., 142:1049-1052, April 8, 1950.

5. Hunt, G. H.: Medical Group Practice in the United States, I. Introduction, New England J. Med., 237:71-77, July 17, 1947.

6. Hunt, G. H.: Medical Groups in the United States, 1946, Public Health Service, Washington, 1949 (second printing).

7. Hunt, G. H., and Goldstein, M.: Medical Group Practice in the United States, II. Survey of Five Groups in New England and the Middle Atlantic States, New Eng. J. Med., 237:719-731, Nov. 13, 1947.

8. Hunt, G. H., and Goldstein, M. S.: Medical Group Practice in the United States, III. Report of a Questionnaire Survey of All Listed Groups, 1946 (reprinted with additions), J.A.M.A., 135:904-909, Dec. 6, 1947.

9. Lueth, H. C.: Economic Aspects of Future Medical Practice, J.A.M.A., 128:528-529, June 16, 1945.